Exhibit A

The Company You Keep ®

LONG-TERM CARE INSURANCE POLICY

Insured: Cynthia L McCullough
Policy No. : [redacted]7701
Policy Date: 11/24/2002

This Policy has many important features. Please read it carefully. New York Life Insurance Company has issued this Policy and will pay its benefits in consideration of your Application and payment of the required premiums.

IMPORTANT POLICY PROVISIONS

Guaranteed Renewable

Your Policy will remain in effect during your lifetime, subject to the terms of the Policy, as long as premiums are paid when due or during the 31 day grace period that follows. We cannot change your Policy without your consent, unless required by federal or state law, but we may change the premium rates. As an additional feature we guarantee that your premiums will not change for a minimum of 3 years, except when required by a change in benefits. After that time, any premium change will be made only on a class basis and will take effect on a Policy Anniversary Date. We will give you written notice of the rate revision at least 45 days prior to the effective date of the premium change.

30 Day Right to Examine Your Policy

You have 30 days from the day you receive your Policy to examine and return it to us. If you are not satisfied with your Policy for any reason within 30 days of receipt, you may return it to us or your agent, with a written request for a full refund of any premium paid. Upon your written request within the initial 30 days, we will return any premium paid and coverage will be void from the start.

No Preexisting Condition Exclusion

Benefits for charges incurred as a result of Preexisting Conditions are payable while this Policy is in force. A Preexisting Condition is any injury or sickness for which you received medical advice or treatment during the 6 months prior to the Effective Date.

Federal Tax-Qualified Coverage

This policy is intended to be a Qualified Long-Term Care Insurance Contract under Internal Revenue Code Section 7702B(b).

NOTICES TO INSUREDS

Caution: We have issued this Long-Term Care Insurance Policy based upon your responses to the questions on your Application. A copy of your Application is attached. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises. If, for any reason any of your answers are incorrect or incomplete, contact us at: New York Life Insurance Company, Long-Term Care, P.O. Box 559005, Austin, Texas 78755-9005.

Notice to Buyer: This Policy may not cover all of the costs associated with Long-Term Care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

IMPORTANT CANCELLATION INFORMATION: PLEASE READ THE PROVISION ENTITLED "WHEN COVERAGE ENDS" FOUND ON PAGE 30.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: If you are eligible for Medicare, review *The Guide To Health Insurance For People With Medicare* available from us.

President

Secretary

COUNTERSIGNED_____
Licensed Resident Agent (Where required by law)

NEW YORK LIFE INSURANCE COMPANY, 51 Madison Ave., New York, New York 10010
Long Term Care, 51 Madison Ave, New York, NY 10010

SCHEDULE OF BENEFITS

This coverage is issued at your address on the Application and is subject to the terms and conditions of the Policy. The Insured named below became covered on the Effective Date for the *Benefits* shown on this Schedule of Benefits.

Name Of Insured: ..... Cynthia L McCullough
Policy Owner: ..... Cynthia L McCullough
Issue Age: ..... Age 41
Policy Number: Redacted7701
Rate Classification: ..... UW Class 4.0 - (2)
Effective Date: 11/24/2002
Anniversary Date: ..... November 24 and each subsequent November 24 thereafter
Premium Due Date: ..... November 24 and each subsequent 24 day of each month following November 24 thereafter

Benefits	**Amounts**	**Premium**
Policy Lifetime Maximum Benefit	Unlimited	
Waiting Period	90 Days	
Nursing Home Benefit		
Maximum Daily Benefit	$273.65	$295.02
Home And Community-Based Care Benefits		
Maximum Daily Benefit	$273.65	
Durable Medical Equipment		
Lifetime Maximum Benefit	$4,000.00	
Informal Care Daily Indemnity Benefit	$136.83	

Riders

Inflation Protection Benefit:
Increase - Annual 5% Coverage Increase Offer

Waiting Period / Waiver of Premium Enhancement Rider

Premium Mode **Quarterly** **TOTAL PREMIUM** **$295.02**

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GLOSSARY

Some words or phrases have special meanings when used in this Policy. These words or phrases are in *Italics* to help you recognize them where they appear. These words and phrases are either included in the Glossary or defined when they first appear in the Policy.

"You", "Your" and "Yourself" refers to the person listed on Page 3 as the Insured and may apply to the Owner if different from the named Insured.

"We", "Our" and "Us" refer only to New York Life Insurance Company.

Activities of Daily Living (ADLs)

Activities of Daily Living means the basic functions we will use to determine your functional capacity. These are:

1. *Dressing* - Your ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn and to fasten or unfasten them.
2. *Eating* - Your ability to move food from a receptacle into the body once it has been prepared and made available to you.
3. *Continence* -Your ability to voluntarily control bowel and bladder function, and to otherwise maintain a reasonable level of personal hygiene.
4. *Toileting* - Your ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing.
5. *Transferring* - Your ability to move in and out of a chair or bed.
6. *Bathing* - Your ability to bathe yourself in the tub or shower, including getting in and out of the tub or shower; or by sponge bath.

Adult Day Care

Adult Day Care means a program that provides preventive, remedial and restorative services to *Chronically Ill Persons* in a protective environment for part of the 24 hour day. The primary purpose of the *Adult Day Care* must be to provide substantial assistance with the *Activities of Daily Living* or substantial supervision which you need for your own safety or the safety of others because of *Cognitive Impairment.*

Adult Day Care Center

Adult Day Care Center means a facility that provides *Adult Day Care* and is properly licensed to do so, if a license is required.

Alternate Plan of Care

Alternate Plan of Care means any *Plan of Care* that is mutually agreed upon by your *Physician* and us as an *Alternate Plan of Care*. Such plan must be a cost effective alternative to care, services or equipment otherwise covered in the Policy.

Assessment

Assessment means an evaluation to determine or verify the degree of loss of your functional capacity or cognitive ability at the time of claim.

Assisted Care Living Facility

Assisted Care Living Facility means a facility that is properly licensed as an *Assisted Care Living Facility* to provide substantial assistance with the *Activities of Daily Living* or substantial supervision due to *Cognitive Impairment* to inpatients, for a daily charge which includes room and board.

If such facility is not required to be licensed to provide these services, it must meet all of the following requirements:

- Provides care and services on an ongoing basis to 10 or more inpatients;
- Provides care to each inpatient in accordance with a *Plan Of Care*; and maintains appropriate records;
- Has staff on duty which is trained to provide the required care and services 24 hours per day;
- Has procedures in place to obtain emergency assistance for its inpatients from appropriate medical personnel;
- Has appropriate methods and procedures in place for administering drugs and biologicals to its inpatients.

Benefit

Benefit means a Policy provision under which benefits may be payable, (e.g. the *Nursing Home Care Benefit).* The terms "benefit" or 'benefits', shown in regular type, refer to amounts we pay or have paid under the Policy.

Care Advisor

Care Advisor means an organization or individual designated by us, to (a) conduct any *Assessment* we request under this Policy and, (b) prepare a *Plan of Care* for our insureds. The *Care Advisor* will be a *Licensed Health Care Practitioner* whose profession and training includes experience in managing and arranging for Long-Term Care Services, or an organization that includes such health care professionals. Only a *Licensed Health Care Practitioner* will prepare a *Plan of Care*.

Chronically Ill Person

Chronically Ill Person means an individual who has been certified within the preceding 12 months by a *Licensed Health Care Practitioner* as:

- Being unable to perform, without substantial assistance from another individual, at least 2 *Activities of Daily Living* due to a loss of functional capacity which is expected to last at least 90 days; or
- Requiring substantial supervision to protect oneself or others from threats to health and safety due to *Severe Cognitive Impairment.*

Cognitive Impairment

Cognitive Impairment means loss or deterioration of intellectual ability determined using standard reliable tests and clinical evidence demonstrating impairment in one or more of the following areas:

- Deductive and abstract reasoning;
- Orientation to person, place and time; and
- Short- or long-term memory.

Loss of intellectual ability can result from Alzheimer's Disease or similar forms of senility or irreversible dementia. *Cognitive Impairment* such that you require continual substantial supervision to protect yourself or others from threats to health and safety will be considered *Severe Cognitive Impairment*.

Durable Medical Equipment

Durable Medical Equipment means a special piece of equipment, which is first purchased or rented for your repeated use at your residence, which enables you to perform one or more of the *Activities of Daily Living* without continual substantial assistance.

Eligible Charges

Eligible Charges means charges you incur for services for which benefits may be payable under the terms of the Policy.

Home Health Agency

Home Health Agency means an agency or organization that is properly licensed to provide *Home Health Care Services* to *Chronically Ill Persons* in their home or residence for an hourly or daily charge. If licensing is not required to provide these services where they are received, the *Home Health Agency* must work under the direction of a *Physician* or nurse, maintain appropriate records, and be engaged on a full-time basis in providing these services.

Home Health Care Services

Home Health Care Services means services provided by a *Home Health Agency* for an hourly or daily charge in your home or residence, including a rest home, to substantially assist you with the *Activities of Daily Living* or to provide substantial supervision which you need for your own safety or the safety of others because of *Cognitive Impairment*. These services may also include related services such as assisting you with ambulating or exercise or with self-administered medications, reporting changes in your condition or needs, completing appropriate records, or maintenance and personal care, when the primary purpose of the services is to substantially assist you with the *Activities of Daily Living* or to provide substantial supervision.

Hospice

Hospice means a facility, agency or organization properly licensed as a *Hospice* in the location where the facility is located or the services are provided. If licensing as a *Hospice* is not required, the facility, agency or organization must be organized to provide palliative care, to alleviate the physical emotional, social and spiritual discomforts of individuals who are *Terminally Ill*, and to provide supportive care to the primary caregiver and the family.

Informal Care

Informal Care means personal care you receive at home from any person who does not reside in your home, including a friend or relative, to substantially assist you in performing the *Activities of Daily Living* or to provide substantial supervision which you need for your own safety or the safety of others because of *Cognitive Impairment*.

Licensed Health Care Practitioner

Licensed Health Care Practitioner means any physician as defined in section 1861(r)(1) of the Social Security Act, or any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury for non-physicians to certify individuals as *Chronically Ill Persons.*

Mental Illness

Mental Illness means a sickness or a condition that is described as a mental or nervous condition as defined by the American Psychiatric Association. Alzheimer's Disease, senility or related dementia, and brain disorders with demonstrable organic cause will not be considered *Mental Illness* under this Policy.

Nursing Home

Nursing Home means a facility or separate portion of a facility which is operated primarily to provide 24 hour care for *Chronically Ill Persons* for a daily charge which includes room and board, and is properly licensed as a *Nursing Home* in the jurisdiction in which it is located. It includes skilled, intermediate and custodial care.

A facility which is not required to be licensed as such in order to operate as a *Nursing Home*, must meet all of the following criteria:

- Has at least 10 beds;
- Provides 24 hour a day nursing services under planned programs and procedures developed and reviewed periodically by a professional group of at least one *Physician* and one registered nurse;
- Has a *Physician* available to furnish medical care in case of emergency;
- Employs at least one registered nurse on the premises full time;
- Has a registered nurse on duty or call at all times;
- Maintains clinical records for all patients; and
- Has appropriate methods and procedures for administering drugs and biologicals.

Nursing Home does not mean any of the following:

- A hospital (except a separate portion of a hospital licensed as a *Nursing Home*);
- A rest home or other residential facility not meeting all of the above criteria; or
- A facility operated primarily for the treatment of alcoholism, drug addiction, or *Mental Illness*.

Period of Care

Period of Care means a single period of time that consists of consecutive days and:

- Begins on the first day you are eligible for the benefits provided by this Policy and you receive any care of a type that is covered under any *Benefit* provision of this Policy; and
- Ends when you have not received any care of a type that is covered under any *Benefit* provision for a period of 180 consecutive days.

During a *Period of Care,* there may be days on which you receive care or services for which no amount is payable under this Policy due to a *Waiting Period*, limitation or exclusion, or because we have paid the maximum benefits for that kind of care.

Physician

Physician means any person who has earned the degree of Medical Doctor (MD) or Doctor of Osteopathy (DO) and is practicing as such within the scope of a license issued by the jurisdiction in which such person's services are rendered.

Plan of Care

Plan of Care means a description and schedule of services and assistance prescribed for a *Chronically Ill Person* by a *Licensed Health Care Practitioner*.

Policy Lifetime Maximum Benefit

Policy Lifetime Maximum Benefit means the maximum dollar amount of benefits that we will pay over your lifetime under this Policy. Except as otherwise expressly provided in this Policy, all of the benefits we pay under this Policy count toward the *Policy Lifetime Maximum Benefit*. This amount is shown on the Schedule of Benefits.

Respite Care

Respite Care means care provided to you to allow a respite to those who normally care for you at home (generally family members, friends or neighbors). Such care may include confinement in a *Nursing Home, Home Health Care Services,* or *Adult Day Care.*

Terminally Ill

Terminally Ill means that a *Physician* has estimated your life expectancy to be less than 12 months.

Waiting Period

Waiting Period means those days at the beginning of a *Period of Care* on which you must incur *Eligible Charges* for care covered under this Policy, before we will pay any benefits. The number of days in the *Waiting Period* is shown on the Schedule of Benefits. These days need not be consecutive, but they must all occur within a single *Period of Care*. Days in a *Period of Care* for which you received care or services of a kind covered both under this Policy and by *Medicare* will count toward meeting the *Waiting Period.*

ELIGIBILITY FOR BENEFITS

You will be eligible for the benefits described in this Policy when:

- You have satisfied the Benefit Eligibility provision below;
- We have completed an Assessment we request;
- You have met the Waiting Period; and
- You have met the Additional Provisions.

Each of these is explained below.

Benefit Eligibility

This explains how you satisfy the Benefit Eligibility provision.

You will be eligible for the *Benefits* provided by this Policy when we determine that you:

- Are unable to perform without continual substantial assistance from another individual 2 or more of the following 6 *Activities of Daily Living: Dressing, Eating, Continence, Toileting, Transferring, and Bathing* due to a loss of functional capacity; or
- Have suffered a *Severe Cognitive Impairment;*

Provided that:

- You must have been certified, within the past twelve months as a *Chronically Ill Person* by a *Licensed Health Care Practitioner;* and
- You must have a *Plan of Care* which prescribes the types of care, services or supplies for which you claim benefits.

You are able to perform an *Activity of Daily Living* if you are able to perform that activity with the aid of equipment, but without continual substantial assistance from another individual.

Benefit Assessments

This explains our right to perform an *Assessment.*

We may perform an *Assessment* to determine whether you are eligible for benefits. You must:

- Notify us as soon as you plan to enter a *Nursing Home*, or *Assisted Care Living Facility*, or begin receiving other care or services, as far in advance as reasonably possible, to permit time for us to perform an *Assessment*; and
- Cooperate with us in performing the *Assessment*.

When we request an *Assessment*, we may perform it ourselves, or we may use a *Care Advisor*. We will not pay any benefits under this Policy until the *Assessment* has been completed. We will pay the cost of the *Assessment.*

Meeting The Waiting Period

This explains your *Waiting Period.*

If the *Waiting Period* applies to a *Benefit* included in this Policy, you must satisfy the *Waiting Period* before we will pay any benefits under that *Benefit* provision. We will count only days on which you receive care or services covered under this Policy, and you meet all of the Policy requirements to be eligible for benefits, except that you have not yet met the Waiting Period. Your *Waiting Period* is shown on the Schedule of Benefits and is explained in the Glossary and here.

Additional Provisions

This explains the additional requirements that apply before any benefits are payable or that apply to the benefits we pay.

No benefits will be payable under any *Benefit* if an Exclusion or Limitation described in this Policy applies.

The benefits we pay under each *Benefit* will count toward your *Policy Lifetime Maximum Benefit*, except as expressly provided in a *Benefit* provision.

The care or services for which you claim benefits must be prescribed in your *Plan of Care*.

This Policy must remain in force, except as provided for *Nursing Home* confinements which commence while this Policy is in force.

BENEFITS INCLUDED IN THIS POLICY

This section describes the benefits we will pay once you have met all of the requirements of the ELIGIBILITY FOR BENEFITS section of this Policy.

- **Nursing Home Care** -- These *Benefits* are available when you are confined.

Nursing Home Care Benefit

This explains your coverage while you are confined in a *Nursing Home,* or *Assisted Care Living Facility*.

We will pay a benefit for each day you are confined in a *Nursing Home* or an *Assisted Care Living Facility*. We will pay:

- The *Eligible Charges* made by the *Nursing Home* or *Assisted Care Living Facility* for that day; up to
- The *Nursing Home* Maximum Daily Benefit shown on your Schedule of Benefits;

Provided that:

- Your stay must begin while your coverage under this Policy is in force.

The *Eligible Charges* of a *Nursing Home* or *Assisted Care Living Facility* include only the daily charge to inpatients for room and board.

The *Waiting Period* applies to this *Benefit*.

Bed Hold Benefit

This benefit reserves your bed in the *Nursing Home* or *Assisted Care Living Facility* during a temporary leave.

Once we have begun paying benefits under the *Nursing Home Care Benefit*, we will pay a benefit for each day you incur *Eligible Charges* to assure that a place will be available for you when you return to a *Nursing Home* or *Assisted Care Living Facility* after a temporary absence. We will pay:

- The facility's normal charge to reserve your place; up to
- The Nursing Home Maximum Daily Benefit shown on your Schedule of Benefits; and up to
- A maximum of 30 days in any calendar year.

The *Eligible Charges* of a *Nursing Home* or *Assisted Care Living Facility* include the facility's normal charge to reserve your place during a temporary absence.

Extended Coverage Benefit

This explains how your benefits may be extended if you are receiving benefits when this Policy lapses.

If you become confined in a *Nursing Home* or *Assisted Care Living Facility* while this Policy is in effect and you continue to be confined, without interruption, after your Policy lapses or terminates, we will extend your benefits by continuing to pay *Nursing Home Care Benefits* for such confinement while you remain so confined.

All of the provisions of this Policy will continue to apply while your coverage is being extended under this *Benefit*. In no event will we pay benefits in excess of the *Policy Lifetime Maximum Benefit*.

- **Home and Community-Based Care** -- These *Benefits* are available when you receive care or services in your home or residence, except in a *Nursing Home* or *Assisted Care Living Facility.*

Home and Community-Based Care Benefit

This benefit allows you to remain at home and receive *Home Health Care Services*.

We will pay a benefit for each day that you receive services from a *Home Health Agency* or an *Adult Day Care Center*. We will pay:

- The *Eligible Charges* made by the *Home Health Agency* or *Adult Day Care Center* for the services provided on that day; up to
- The Home and Community-Based Care Maximum Daily Benefit shown on your Schedule of Benefits;

Provided that:

- *Eligible Charges* must begin while your coverage under this Policy is in force; and
- No benefits are payable under this *Benefit* for any day on which we pay *Nursing Home Care Benefits* or other benefits because you are confined.

The *Eligible Charges* of a *Home Health Agency* or *Adult Day Care Center* include only its normal charges for services provided to you, when you have become a *Chronically Ill Person,* to substantially assist you with the *Activities of Daily Living* or to provide substantial supervision which you need for your own safety or the safety of others because of Cognitive Impairment. These *Eligible Charges* may also include the *Home Health Agency's* normal charges for related services such as assisting you with ambulating or exercise or with self-administered medications, reporting changes in your condition or needs, completing appropriate records, or maintenance and personal care, when the primary purpose of the services – during each 4 hour period you receive services -- is to substantially assist you with the *Activities of Daily Living* or to provide substantial supervision which you need for your own safety or the safety of others.

We may require a *Home Health Agency* or *Adult Day Care Center* to provide sufficient information for us to determine whether its charges to you are *Eligible Charges*, before paying any benefits under this *Benefit*.

The *Waiting Period* applies to this *Benefit*.

Informal Care Benefit

This provides payment for *Informal Care* received from people such as family and friends who do not reside in your home.

We will pay a benefit for each day on which you receive *Informal Care* during a *Period of Care*. We will pay:

- The *Informal Care* daily indemnity benefit shown on the Schedule of Benefits; up to
- A Lifetime maximum of 365 days while your coverage is in force under this Policy;

Provided that:

- No daily benefit is payable under this *Benefit* for any day for which we pay benefits under any other *Benefit* provision.

The *Waiting Period* does not apply to this *Benefit*, and the days on which we pay benefits under this *Benefit* does not count toward satisfying the *Waiting Period.*

We will pay these *Informal Care* benefits monthly.

Durable Medical Equipment Benefit

This benefit provides for special equipment that you may need to perform the *Activities of Daily Living.*

We will pay the charges you incur to purchase or rent *Durable Medical Equipment*, up to the *Durable Medical Equipment Lifetime Maximum Benefit* shown on the Schedule of Benefits;

Provided that:

- The *Durable Medical Equipment* must be prescribed in your *Plan of Care* and be first purchased or rented after the Effective Date of the Policy;
- The *Durable Medical Equipment* must enable you to perform any of the *Activities of Daily Living* and allow you to remain in your home for an expected period of at least 90 days after the purchase or rental; and
- The *Durable Medical Equipment* must not materially increase the value of your home.

The *Waiting Period* does not apply to this *Benefit*.

Any benefits we pay under this *Benefit* will not be considered daily benefits.

Special Claims Note: Proof of Loss for *Durable Medical Equipment* will include an itemized bill for the purchase or rental showing the date the equipment was received.

Care Advisor Coordination Benefit

This benefit provides for the services of a *Care Advisor*.

We will pay the *Care Advisor's* charges to prescribe a *Plan of Care* for you, if you request the *Care Advisor* to do so. We will pay these charges once per *Period of Care*, except as provided below. If you request a *Plan of Care* from the *Care Advisor*, you may still, at any time but at your own expense, obtain another *Plan of Care* from a *Licensed Health Care Professional* you choose, if you prefer not to follow the *Plan of Care* prescribed by the *Care Advisor*. While you are following the *Plan of Care* prescribed for you by the *Care Advisor,* we will also pay:

- The *Care Advisor's* charges to certify that you remain a *Chronically Ill Person* and to prescribe a current *Plan of Care* for you annually; and
- The *Care Advisor's* charges to coordinate the services you receive under your *Plan of Care.*

There is no *Waiting Period* to use the *Care Advisor*, and the amounts we pay the *Care Advisor* do not count against the *Policy Lifetime Maximum Benefit.* You must, however, satisfy the applicable *Waiting Period* before we will pay benefits for any care or services the *Care Advisor* coordinates, and the benefits we pay will count against the *Policy Lifetime Maximum Benefit* as provided in each *Benefit*.

Advantages of using this benefit.

While you are following the *Plan of Care* provided by the *Care Advisor*, we will also enhance your *Home and Community-Based Care Benefit as follows:*

- We will reduce the *Waiting Period* shown on the Schedule of Benefits by 30 days; (but not if the *Waiting Period* shown is 30 days or less.) and;
- We will determine your benefits for *Home and Community-Based Care* on a weekly, rather than daily basis. This means that we will pay the *Eligible Charges* you incur from a *Home Health Agency or Adult Day Care Center* during any calendar week (Sunday through Saturday), up to seven (7) times the *Home and Community-Based Care Maximum Daily Benefit* shown on the Schedule of Benefits;

Provided that:

- No *Informal Care* benefits are payable during any week we determine your *Home and Community-Based Care* benefits on this weekly basis.
- All other provisions of the *Home and Community-Based Care Benefit* will continue to apply.

Informal Caregiver Training Benefit

This benefit provides training for an informal caregiver to provide *Informal Care* for you at home.

We will pay the cost of training a person to provide you with *Informal Care* in your home; up to a lifetime maximum of 5 times *the Nursing Home Maximum Daily Benefit* shown on your Schedule of Benefits;

Provided that:

- The training must be prescribed in your *Plan of Care;*
- The training cannot be received while you are confined in a hospital, *Nursing Home or Assisted Care Living Facility* unless it is expected that you will return home where the person that is receiving the training can care for you; and
- We will not pay any benefits to train an individual who will be providing any care other than *Informal Care* for you.

You do not have to meet the *Waiting Period* to use this *Benefit*. The benefits we pay under this Benefit are not considered a daily benefit, and days on which any person is being trained under this *Benefit* do not count toward the *Waiting Period*.

Respite Care Benefit

This benefit provides coverage for a temporary *Nursing Home* confinement or temporary period of *Home and Community-Based Care* after you have received care on an informal basis for a period of time.

We will pay a benefit for each day you receive care to allow those caring for you at home to get temporary relief (for example, for a holiday, vacation, or emergency). We will pay:

- The *Eligible Charges* of a *Nursing Home*, *an Assisted Care Living Facility*, a *Home Health Agency* or *Adult Day Care Center* for each day you receive care, up to
- The *Nursing Home Maximum Daily Benefit* shown on your Schedule of Benefits if you are confined in a *Nursing Home* or *Assisted Care Living Facility*; or up to
- The greater of:
  - Fifty percent (50%) of the *Nursing Home Maximum Daily Benefit*; or
  - The *Home and Community-Based Care Maximum Daily Benefit* shown on your Schedule of Benefits, if you receive care from a *Home Health Agency* or *Adult Day Care Center*;

  and up to
  - 21 days per calendar year.

You do not have to meet the *Waiting Period* before we will pay benefits under this *Benefit* and the days for which we pay benefits under this *Benefit* do not count toward satisfying the *Waiting Period*.

Hospice Care Benefit

This benefit provides coverage for care you receive from a *Hospice.*

If you become *Terminally Ill,* for each day you receive Care provided by a *Hospice*, we will pay:

- The *Eligible Charges* of the *Hospice*; up to
- The *Nursing Home Maximum Daily Benefit* amount.

Provided that:

- You meet all of the requirements of the ELIGIBILITY FOR BENEFITS section of the Policy.

The *Waiting Period* does not apply to this *Benefit*, and the days on which we pay benefits under this *Benefit* do not count toward satisfying the *Waiting Period.*

Alternate Plan of Care Benefit

This benefit provides for a cost effective alternate plan mutually agreed upon.

Once you have met all of the conditions of the ELIGIBILITY FOR BENEFITS section, you may request an *Alternate Plan of Care*. If we agree, we will pay benefits in accordance with the *Alternate Plan of Care*.

Examples: An *Alternate Plan of Care* may call for the use of facilities, providers or other items not otherwise covered by the Policy such as:

- Additional equipment;
- Additional home safety devices;
- Stays in other types of facilities;

The following additional terms apply under this *Benefit*.

- Except as we expressly agree in the *Alternate Plan of Care*, your rights and ours will be governed by all of the Policy terms.
- All of the benefits we agree to pay under the *Alternate Plan of Care* must be for Qualified Long-Term Care Services as defined in Internal Revenue Code Section 7702B(c).
- We may agree with you only for a set period of time (for example, one year). At the end of that period of time, the *Alternate Plan of Care* will end unless we agree with you to renew it. You may terminate an *Alternate Plan of Care* at any time, by giving us at least (15) days advance written notice of the termination.
- After an *Alternate Plan of Care* terminates we will resume paying benefits for expenses you incur in accordance with all of the Policy terms.
- *Alternate Plans of Care* are necessarily unique to each insured, and we reserve the right to decline to agree to any such request, or to any proposed term of an *Alternate Plan of Care*, but we will consider all requests for an *Alternate Plan of Care* on a non-discriminatory basis.

Waiver of Premium Benefit

This benefit waives your premiums after you have satisfied the *Waiting Period* and have been receiving benefits for 90 days.

We will waive the premium payments which become due for your coverage under this Policy once we have paid benefits under the *Nursing Home Care Benefit* for 90 days, or for 90 days of services (other than for *Informal Care*) under the *Home and Community-Based Care Benefit.*

We will waive the premiums which become due after you have met this requirement, and we will continue to waive these premiums so long as you receive care during that *Period of Care*. Once you no longer qualify for this *Benefit*, you must resume paying premiums in order to keep this Policy in force.

If your premium has already been paid for a period for which premiums are waived, we will refund the premiums paid for that period. We will waive or refund premiums beginning on the first day of the first month after you become entitled to a waiver, and you must start paying premiums beginning on the first day of the first month after you are no longer entitled to a waiver. This rule applies without regard to the mode of premium payment shown on the Schedule of Benefits.

EXCEPTIONS AND LIMITATIONS

This section explains the General and Specific Exclusions and Limitations that apply to all of the *Benefits* included in this Policy. We will not pay any benefits, or will reduce the benefits we pay whenever an Exclusion or Limitation applies to your claim. We will not apply any Exclusion or Limitation where not permitted by applicable law. Whenever an Exclusion or Limitation applies to eliminate or reduce our payment, only the actual amount we pay will count against the *Policy Lifetime Maximum Benefit*.

General Exclusions and Limitations

We will not pay any benefits under any *Benefit* included in this Policy for charges you incur:

- Due to war, whether declared or undeclared;
- Due to attempted suicide, or any intentionally self-inflicted injury;
- As a result of voluntary participation in a riot or attempting to commit an assault or felony;
- For a facility or agency located outside of the United States and its territories;
- Which would not be made in the absence of this insurance;
- For treatment of alcoholism and drug addiction unless the drug addiction was a result of the administration of drugs as part of treatment by a *Physician;*
- For any *Mental Illness*. However, we will not apply this exclusion to any charges you incur in connection with a brain disorder with demonstrable organic cause, or which are made in connection with senility, irreversible dementia, Alzheimer's disease or Parkinson's disease;
- For treatment provided in a government facility unless we are required by law to cover the charges;
- For treatment of an injury or sickness which would entitle you to benefits under any state or federal workers' compensation, employers' liability or occupational disease law;
- From family members (except as explicitly provided under the *Informal Care Benefit*);
- For prescription drugs;
- To the extent that benefits are payable by *Medicare* or would be payable except for the application of a deductible or coinsurance amount;
- For items of comfort such as toiletries, television rental, laundry charges, beauty and hair charges, or *Nursing Home* miscellaneous or ancillary charges beyond the daily charges for room and board, including therapy and any other items of comfort.

Specific Exclusions and Limitations

Overall Maximum Daily Benefit

The *Nursing Home* Maximum Daily Benefit shown on the Schedule of Benefits is also the maximum amount we will pay under this Policy and any attached riders on account of all of the *Eligible Charges* you may incur on any day. This limitation applies even if benefits would be payable under more than one of the *Benefit* provisions included in this Policy and any attached riders.

Policy Lifetime Maximum Benefit

No additional benefits are payable under this Policy once we have paid benefits equal to the *Policy Lifetime Maximum Benefit.*

Chronic Illness Certification

No benefits are payable under this Policy for charges you incur on any day for which you are not certified as a *Chronically Ill Person.* You are responsible for keeping your certification current.

Care Not Included in a Plan Of Care

No benefits are payable under this Policy for charges you incur for care, services or equipment unless the care, services or equipment is included in your current *Plan of Care*.

Effect of Federal Law

No benefits are payable under this Policy which would cause this Policy to fail to qualify as a Qualified Long-Term Care Insurance Contract under Section 7702B(b) of the Internal Revenue Code.

EFFECT OF OTHER COVERAGE

This section explains how other coverage you may have, including Medicare, will affect the benefits we pay under this Policy.

Effect of Medicare

The benefits payable under this Policy will not duplicate any benefits provided by *Medicare*. When you are *eligible for Medicare,* we will pay as follows:

- For type of charges covered by this Policy and by *Medicare* (other than as a secondary payor), we will reduce your benefits under this Policy so that its benefits plus *Medicare* benefits are equal to 100% of all such charges up to the *Nursing Home* Maximum Daily Benefit shown on your Schedule of Benefits. To the extent required under Internal Revenue Code Section 7702B(b), your *Medicare* benefits will be treated as including amounts not reimbursable by *Medicare* due to the Application of a deductible or coinsurance amount.
- For types of charges covered by this Policy, but not covered by *Medicare* or covered by *Medicare* only as a secondary payor, we will pay the regular benefits due under this Policy.
- When you are *eligible for Medicare*, we will pay benefits under this Policy based on your having full *Medicare* coverage (Part A and Part B). We will not pay any benefits under this provision which would cause this Policy to fail to be a Qualified Long-Term Care Contract under Internal Revenue Code Section 7702B(b).

"*Medicare*" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. You are *eligible for Medicare* -- Part A, if you are either enrolled in *Medicare* Part A, or could become enrolled by making application. You are *eligible for Medicare* -- Part B if you are either enrolled in *Medicare* Part B, or could have become enrolled by making application and paying any required premium, even if you currently would have to wait to enroll in or to become covered under *Medicare* Part B.

Effect of Workers' Compensation Benefits

The benefits provided under this Policy will not duplicate *Workers' Compensation Benefits*. If you receive care or services, or incur charges for which benefits may be available under any *Benefit* provision, on account of an occupational injury or sickness, benefits will be payable under this Policy only in excess of your *Workers' Compensation Benefits.*

"*Workers' Compensation*" means benefits paid or payable under any state or federal workers' compensation, employers' liability, or occupational accident or disease law.

CLAIMS

This section explains how to make your claims under this Policy, and how they will be paid.

Notice of Claim

Written Notice of Claim must be given to us at New York Life Insurance Company, Long-Term Care, P.O. Box 559005, Austin, Texas 78755-9005 or to any authorized agent. The notice must include your name and Policy Number. The notice must be given to us within 60 days after a covered loss occurs or begins, or as soon as reasonably possible.

Claim Forms

When we receive a notice of claim, we will give you forms for filing a Proof of Loss. This proof must be given to us within the time limit stated in the "Proof of Loss" provision. If we do not provide these forms to you within 15 days after we receive a notice of claim, you need not use such form if, instead, you give us written proof of the nature and extent of the loss.

Whether or not our claim form is used, Proof of Loss will also include copies of medical records from your primary *Physician(s)* and provider(s) of health care services.

Proof of Loss

Proof of loss must be given to us in writing at New York Life Insurance Company, Long-Term Care, P.O. Box 559005, Austin, Texas 78755-9005. In case of a loss for which this Policy provides any periodic payment contingent upon continuing loss, proof of loss must be given to us within ninety (90) days after the termination of the period for which we are liable. In the case of a claim for any other loss, proof must be given to us within ninety (90) days after the date of loss. Failure to give us the proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the proof must be given as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims

We will pay benefits for any loss covered by this Policy only after we have received due written proof of loss. We will pay benefits on a monthly basis after services have been rendered. We will pay benefits for *Informal Care* Monthly.

Manner of Payment

While you are living all *Nursing Home* benefits will be paid to you or at your request, or when required by law, to a provider who has furnished covered services to you. Any outstanding *Nursing Home Benefits* that have not been paid at the time of your death will be paid to your estate unless otherwise required by law.

All benefits for *Home and Community-Based Care* you receive will be paid to you.

At our option, we may pay any benefit of $1,000 or less to an alternative payee.

Physical Examination

We may examine you or request the *Care Advisor* to perform an *Assessment* of you when and as often as we may deem reasonable before paying any benefit. Any such examination or *Assessment* will be at our expense. You must cooperate with the examination or *Assessment.*

Legal Actions

With respect to any claim under this Policy, no legal action may be taken against us during the 60 days after receipt of the written proof of claim, or after 3 years from the date the proof of claim is required to be given.

Appealing a Claim

We will inform you in writing if a claim or any part of a claim is denied. If you believe that our claim decision is in error, we will reconsider your claim. You must send us a written letter explaining why we should change our decision. You may authorize someone else to act for you in the appeal process.

Your Letter should include the names, address and telephone numbers of all *Physicians*, care coordinators, other health care professionals or facilities where you received care, treatment, services, equipment and other items that you think we should consider in reviewing your physical or mental condition.

Once we have completed our review we will notify you in writing and pay any benefits due as a result of our reconsideration.

PREMIUMS AND REINSTATEMENT

This Section explains how you will pay your premiums.

Initial Premium Rates

The initial premium rates for the Benefits included in your Policy are shown on your Schedule of Benefits.

Payment of Premiums

Payment of the initial premium will keep this Policy in effect for the initial premium payment period. This period starts at 12:01 A.M. on the Effective Date. It ends at midnight of the day before the next Premium Due Date, subject to the "Grace Period" provision. The mode, or period, of premium payment is shown on the Schedule of Benefits. The above times refer to Standard Time at the place where you then reside. Each premium, after the first, is due at the end of the period for which the preceding premium was paid.

Premiums must be paid to New York Life Insurance Company, Long-Term Care, P.O. Box 559005, Austin, Texas 78755-9005 or to any other address that we designate. Payment of a premium will not keep this Policy in effect beyond the period for which it is paid, except as may be otherwise provided in this Policy.

Changes in Premiums

We have the right to increase your premium rates as of any Premium Due Date on or after the 3rd Anniversary Date of your Policy. Any increase on or after that date will only be made on a class basis, and will take effect on an Anniversary Date.

We will mail you written notice of your new premium rates at least 45 days before the Effective Date of the new premium.

We may change your premium rates due to a change in the requirements of applicable federal law, as explained below.

Grace Period

This Policy has a 31 day grace period. This means that if a premium after the initial premium is not paid by the date it is due, it may be paid during the 31 day period following that date. This policy will not lapse or be terminated for nonpayment of premium unless we, at least 30 days before the effective date of the lapse or termination, have given notice to you and to third party designation, at the address provided by you for purposes of receiving notice of lapse or termination. Notice will be given by first class United states mail, postage prepaid, and notice will not be given until 30 days after a premium is due and unpaid. Notice is considered to have been given as of five days after the date of mailing.

Reinstatement

If a renewal premium is not paid before the end of its grace period, this Policy will terminate. If we later accept and retain a premium, without requiring an application for reinstatement, the Policy will be reinstated. If an application is required by us, we will issue a conditional receipt for the premium paid. If the application is approved, and all unpaid overdue premiums have been paid, the Policy will be reinstated as of the approval date. If it is disapproved, we will inform you in writing within 45 days after the date of the conditional receipt. If we fail to so inform you the Policy will be reinstated upon such 45th day.

The reinstated Policy will cover only loss due to an injury sustained or physical or mental condition which begins after the date of reinstatement. Except for this and any new provisions added in connection with reinstatement, your rights and ours under this Policy will be the same as they were just before the Policy terminated. For purposes of this provision only, an illness, physical or mental condition will be considered to have begun when advice is supplied or treatment is recommended by or received from a *Physician.*

Third Party Designation

If you have made a *Third Party Designation* in your Application, we will notify you and the person that was designated 30 days after the premium due date for which premiums were not paid and allow another 30 days for that premium to be paid.

Added Protection Against Lapse

If your Policy terminates because you did not pay the premium due to a *Cognitive Impairment* or a loss of 2 or more *Activities of Daily Living*, we will reinstate your Policy if you request reinstatement within 5 months of the date of termination and you meet both of the following:

- You furnish us with satisfactory proof of a *Cognitive Impairment* or a loss of 2 or more *Activities of Daily Living,* and
- You pay all the unpaid overdue premiums.

This provision applies only to the named Insured.

COVERAGE PROVISIONS

The following provisions explain when your coverage under this Policy starts, how long it continues, and when it will end.

When Coverage Begins

Your coverage begins on the Effective Date shown on the Schedule of Benefits; provided that, we must deliver the Policy and you must pay the initial premium, in full. You may only pay the initial premium before or within 30 days after the Effective Date, after which we may decline to deliver the policy and cancel it as of the Effective Date. In this case, your coverage will never become effective.

Continuation of Coverage

Your coverage will continue as long as you pay the required premiums under this Policy and do not exhaust the *Policy Lifetime Maximum Benefits.*

When Coverage Ends

Your coverage under this Policy will end when the first of the following occurs:

- The last day of the *Grace Period* for the payment of any premium;
- The day the *Policy Lifetime Maximum Benefit* is exhausted; or
- The first day of the following month after you notify New York Life in writing that you wish to terminate your coverage.

If you have paid the premium for coverage beyond this date, we will promptly refund any of the unearned premium to you.

GENERAL PROVISIONS

The following general provisions apply to your coverage under this Policy.

Policy Ownership

The Owner is the person named as the Insured on the Policy Schedule, unless another person is named the Owner on the Application and Policy. If the Insured is not the Owner and the Owner dies before the Insured, the Insured will become the new Owner unless the Owner before death or the Insured designates another person to become the Owner. The Owner has all rights and privileges granted by Ownership of this Policy during the Insured's lifetime.

Misstatement of Age

If your age has been misstated, the *Benefits* included in your Policy will be those that the premium paid would have purchased at your correct age. If we would not have issued a Policy had your age been correctly stated, our liability under the Policy will be limited to a refund of the premiums paid.

Entire Contract and Changes

This Policy, together with your Application and any optional riders or attached documents, is the entire contract of insurance. No change in this Policy will be valid until approved by our President or Secretary. To be valid, such approval must also be endorsed on or attached to this Policy. No agent has authority to change your Policy. If we change our address or any toll-free telephone number, we will notify you.

Assignment

This Policy may not be assigned.

Protection Against Creditors

Payments made under this Policy are, to the extent law permits, exempt from the claims, attachments, or levies of any creditors.

Conformity with State and Federal Laws and Regulations

Any provision of this Policy which, on the Effective Date, is in conflict with the requirements of any federal law or regulation or any law or regulation of the state in which you reside on that date is amended to conform to the minimum requirements of such laws and regulations.

Tax-Qualification under Federal Laws

This Policy is intended to be a Qualified Long-Term Care Insurance Contract under Internal Revenue Code Section 7702B(b). We may amend it at any time as necessary to meet the requirements of that law, any successor law, or any applicable regulations. If this Policy may be amended in more than one way to meet the foregoing requirements, we may determine how to best do so. If any such amendment affects the risk we assumed, we may make an equitable premium adjustment.

Time Limit on Certain Defenses

If this Policy has been in effect for less than six months we may rescind it or deny an otherwise valid claim if the Application contained a misrepresentation that is material to the acceptance of your Application.

If this Policy has been in effect for at least six months but less than two years, we may rescind it or deny an otherwise valid claim if the Application contained a misrepresentation that is both:

- Material to the acceptance of your Application; and
- Pertains to the condition for which the claim is made.

After the Policy has been in effect for two years, we may not rescind it unless you knowingly and intentionally misrepresented relevant facts relating to your health.

If this Policy is rescinded after we have paid benefits, we may not recover the payments already made.

Right to Recovery

If we make payments with respect to benefits in a total amount which is, at any time, in excess of the benefits payable under the provisions of this Policy, we will have the right to recover such excess from you, or from any persons or providers to, or for, or with respect to whom, such payments were made. We may withhold future benefit payments in order to do so.

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NEW YORK LIFE INSURANCE COMPANY

Long Term Care
51 Madison Ave
New York, NY 10010

LTC 4.0 INSURANCE POLICY
INFLATION PROTECTION RIDER Annual 5% Coverage Increase Offer

This Rider attaches to and becomes part of Your Policy. Please read it carefully and attach it to your Policy. This Rider is issued based on your written request, a copy of which is attached, and payment of the initial premium in full. Future premiums for Your Policy include the premium for this Rider and are payable under the terms of the Policy.

Insured:	Cynthia L McCullough	**Premium Mode:**	Quarterly
Issue Age:	41	**Premium:**	
Policy Number:	Redacted7701		
Effective Date:	11/24/2002		

Inflation Protection Option

This tells how certain benefits can be increased with inflation.

5% Annually – 4 refusals, no further offer.

If no other Inflation Protection Option is selected then You will automatically receive this benefit. On the first anniversary of the Policy, and on each subsequent anniversary, We will offer You the opportunity to increase Your *Nursing Facility Maximum Daily Benefit, the Home and Community-Based Care Maximum Daily Benefit*, if applicable, as well as Your *Policy Lifetime Maximum Benefit* by five percent from their levels at the time that the offering is made. You will pay for the additional benefit at Your attained age. The increase offer will be considered declined unless you notify us in writing of your election to accept the increase within 31 days of the nearest anniversary of the Policy. Once You have declined the offer four times, no further offers will be made.

Signed for New York Life Insurance Company:

President *Secretary*

Countersignature (Where required by law)

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

(please turn to back of page)

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- A policy or contact commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

1. The act also limits the amount the association is obligated to pay out as follows: The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
2. Except as provided in (3), (4), and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
3. The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
4. The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
5. The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

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Long Term Care
51 Madison Ave
New York, NY 10010

LTC 4.0 INSURANCE POLICY
Waiting Period/Waiver of Premium Enhancement Rider

This Rider attaches to and becomes part of your Policy. Please read it carefully and attach it to your Policy. This Rider is issued with your Policy at the time of issue, or is being added at a later date, at your written request, as an enhancement of the Waiting Period and the Waiver of Premium provisions of the Policy. There is an additional premium charge for this Rider and that additional premium is shown below. This Rider is subject to all the terms and conditions of the Policy which are not in conflict with this Rider. This Rider is effective on the Policy Effective Date, shown below, if this Rider is issued with the Policy, otherwise this Rider is effective on the Rider Effective Date shown below.

Insured:	Cynthia L McCullough	**Premium Mode:**	Quarterly
Original Issue Age:	41	**Premium:**	
Policy Number:	[Redacted]7701	**Rider Effective Date:**	11/24/2015
Policy Effective Date:	11/24/2002		

The definition of *Waiting Period* in the Policy Glossary is deleted and replaced by the following:

Waiting Period	*Waiting Period* means those days occurring while this Policy is in force on which you must incur *Eligible Charges* for care covered under this Policy before we will pay any benefits. The number of days in the *Waiting Period* is shown on the Schedule of Benefits. These days need not be consecutive. Days for which you received care or services of a kind covered both under this Policy and by *Medicare* will count toward meeting the *Waiting Period*. Only one *Waiting Period* needs to be satisfied during the lifetime of this Policy before benefits are payable for covered care.

The **Meeting the Waiting Period** provision of the Policy is amended by the inclusion of the following sentence:

Only one *Waiting Period* needs to be satisfied during the lifetime of this Policy.

The **Waiver of Premium Benefit** provision in the **BENEFITS INCLUDED IN THIS POLICY** section of the Policy is amended by deleting that provision in its entirety and substituting the following:

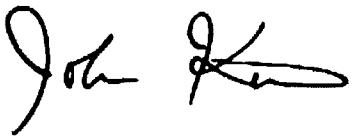
Waiver of Premium Benefit	We will waive the premium payments which become due for your coverage under this Policy once you have satisfied the *Waiting Period* and we have started paying benefits under the *Nursing Home Care Benefit* or under the *Home and Community-Based Benefit* (other than for *Informal Care*).

This benefit waives your premiums after you have satisfied the *Waiting Period* and are receiving benefits.

We will waive the premium which becomes due after you have met this requirement, and we will continue to waive these premiums so long as you receive care during that *Period of Care*. Once you no longer qualify for this *Benefit*, you must resume paying premiums in order to keep this Policy in force.

If your premium has already been paid for a period in which premiums are waived, we will refund the premiums paid for that period. We will waive or refund premiums beginning on the first day of the first month after you become entitled to a waiver, and you must start paying premiums beginning on the first day of the first month after you are no longer entitled to a waiver. This rule applies without regard to the mode of premium payment shown on the Schedule of Benefits.

Signed for New York Life Insurance Company:



President

Secretary

Countersignature (Where required by law)

NEW YORK LIFE INSURANCE COMPANY
Long Term Care
51 Madison Ave
New York, NY 10010

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POLICY ENDORSEMENT

Additional Definitions and Deletion of Exclusion Mental Illness

This Endorsement attaches to and becomes part of your Policy. Please read it carefully and attach it to your Policy. This Endorsement is issued with your Policy at the time of issue, or is being added at a later date, as an expansion of the definitions of terms and coverage in your Tax Qualified Long-Term Care Insurance Policy. There is no additional premium charge for this Endorsement. This Endorsement is subject to all the terms and conditions of the Policy which are not in conflict with this Endorsement.

Insured:	Cynthia L McCullough	**Policy Effective Date:**	11/24/2002
Original Issue Age:	41	**Endorsement Effective Date:**	11/24/2002
Policy Number:	[redacted]7701		

The following definitions and provisions are hereby added to the Policy referenced above:

Substantial Assistance	Substantial Assistance means Hands-on Assistance or Standby Assistance.
Hands-on Assistance	Hands-on Assistance means the physical assistance of another person without which the individual would be unable to perform the ADL.
Standby Assistance	Standby Assistance means the presence of another person within arm's reach of that individual that is necessary to prevent, by physical intervention, injury to the individual while performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower as a part of bathing, or being ready to remove food from the individual's throat if the individual chokes while eating).
Substantial Supervision	Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Severe Cognitively Impaired individual from threats to his or her health or safety (such as may result from wandering).
Mental Illness	Coverage is provided under the Policy for Mental Illness by removing the Mental Illness exclusion from the General Exclusions and Limitations provision in the EXCEPTIONS AND LIMITATIONS section of the Policy, provided that you are clinically diagnosed with any Mental Illness and required Substantial Assistance with 2 or more of the Activities of Daily Living or require Substantial Supervision due to a Severe Cognitive Impairment.
	The last bullet of the Nursing Home definition has changed to read: • A facility operated primarily for the treatment of alcoholism or drug addiction.

Signed for New York Life Insurance Company:

President *Secretary*

Countersignature (Where required by law)

ALTC-4009-PLUS(0599)

LONG-TERM CARE INSURANCE
POLICY ENDORSEMENT
POLICY DIVIDENDS -- PARTICIPATING

The Company You Keep®

NEW YORK LIFE INSURANCE COMPANY
New York Life, Long-Term Care, 51 Madison Ave, New York, NY 10010

Policy Endorsement – Policy Dividends -- Participating

Insured: Cynthia L McCullough
Issue Age: 41
Policy Number: [Redacted]7701

Policy Effective Date: 11/24/2002
Endorsement Effective Date: 11/24/2002

This Endorsement attaches to and becomes part of the Policy indicated by the Policy Number above. **Please read this Endorsement carefully**. If this Endorsement is being issued with the Policy, it is attached to the Policy. If this Endorsement is being added after the Policy Effective Date, then this Endorsement should be attached to the Policy. There is no premium for this endorsement and future premiums for the Policy remain payable under the terms of the Policy.

The following provision is added to the Policy:

Policy Dividends

A dividend may be apportioned to the Policy Owner on the 3rd Policy Anniversary and each Policy Anniversary thereafter, if:

- All premiums due up to that Policy Anniversary have been paid; and
- We find that a part of Our divisible surplus is to be apportioned to the Policy as a dividend as declared by Our Board of Directors.

If the Policy premiums are being waived on the Policy Anniversary under the Waiver of Premium benefit in the Policy, the dividend will be paid in the form of an additional benefit, as determined by Us.

If the Policy remains in force after the Policy Anniversary, and premiums are not being waived under the Waiver of Premium benefit in the policy, the dividend will be used to reduce future premiums.

If the Policy lapses on the Policy Anniversary, the dividend will be paid directly to the Policyowner.

No dividend will be provided if the policy is in a paid-up premium status on the Policy Anniversary.

Dividend Declaration Disclosure

While We may declare dividends on an annual basis, there is no guarantee that dividends will be declared or paid each year.

Sign for New York Life Insurance Company:

President

Secretary